

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003748

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JAN 25 1962

1. PLACE OF DEATH

a. COUNTY

1 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY

admission)

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

c. CITY

OR TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION

Chronic Hosp.

Inside Limits

Yes ☒ No ☐

d. STREET (If outside, give location)

ADDRESS

4612 Washington

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

EUGENE

FLIPPIN

4. DATE OF DEATH

Month

Day

Year

JAN. 16 1962

5. SEX

Male

6. COLOR OR RACE

Col.

7. Married ☐Never Married ☐Widowed ☐Divorced ☒

8. DATE OF BIRTH

5-3-1885

9. AGE (last birthday)

76

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

10b. KIND OF BUSINESS OR INDUSTRY

Thea

11. BIRTHPLACE (City and state or country)

Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

Unk.

13b. MOTHER'S MAIDEN NAME

Unk.

14. NAME OF HUSBAND OR WIFE

None

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

George Flipping 4612 Washington

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

Approx 5 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Unrelieved arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11-27-61 to 1-16-62 and last saw her him alive on 1-16-62

Death occurred at 4:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

J. McClendon 4535 Washington Blvd

JAN 17 1962

Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

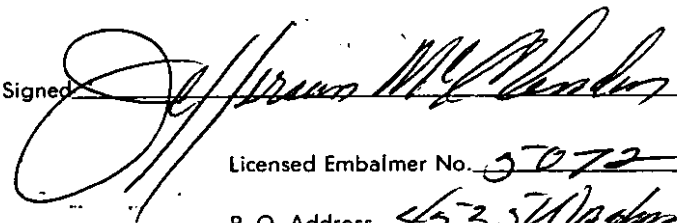
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 5072

P. O. Address 4535 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).¹

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.